ARTICLE

Reducing Stigma by Meeting and Learning from People with Mental Illness

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Objective: This study examines the effects of a public education program, developed in large part by consumers of mental health services, on the attitudes of high school students toward people with mental illnesses. Methods: Four hundred and twenty-six students were provided an informational session delivered by consumers and a faculty member from the University of Medicine and Dentistry of New Jersey (UMDNJ). The content of these sessions included facts about mental illness, characteristic symptoms, recovery strategies, and personal stories told by the consumer presenters. The students' attitudes were assessed pre- and post-session using the Attribution Questionnaire—Short Form for Children. Independent samples t-tests were used to assess changes in attitudes from pre- to post-assessment. Results: After viewing these presentations, students reported less stigmatizing views toward people with mental illness on seven of the nine factors and the total scale score. Conclusions: A 1-hour informational session developed and facilitated by consumers of mental health services can significantly affect the attitudes of adolescents toward people with major mental illnesses. Future studies will evaluate the sustainability of attitude changes as the result of these presentations, as well as the effects of demographic and socioeconomic differences on attitude change.

Keywords: anti-stigma, education program, mental illness, attitude change

Over the last decade, stigma reduction has become an increasingly important topic for research, public health campaigns, clinical care, advocacy, and policy development. Around the world there are programs in place to reduce the stigma associated with mental illness, and a knowledge base to support the efficacy of these initiatives is emerging (World Health Organization, 2001). Educational programs aimed at reducing stigmatizing attitudes that provide opportunities for personal contact with people with mental illness have shown the most promising results.
Effects of Stigma

Widespread stigmatizing beliefs and stereotypes about people with mental illnesses are well documented (Albrecht, Walker, & Levy, 1982; Corrigan, 2003; Phelan & Link, 1998; Weiss, 1994). Research has found that mental illness is one of the most stigmatized conditions in our society, regardless of the specific psychiatric diagnosis (Corrigan & Lundin, 2000; Corrigan & Penn, 1999; Tringo, 1970; Weiner, Perry & Magnusson, 1988). Stigma creates major barriers for people with mental illnesses and often prevents them from accomplishing many of their life goals (Corrigan, 2003). The negative effects of stigma toward people with mental illnesses can influence all life domains, including living, learning, working, and socializing. Research has documented that stigma is experienced both externally and internally. The external effects of stigma refer primarily to discrimination against people with mental illnesses with regard to housing, work, and social interactions (Hinshaw & Cicchetti, 2000). The results of one study reported that 52% of the respondents surveyed stated that they experienced discrimination as a result of receiving mental health services and 41% indicated they have been treated differently all or most of the time after their psychiatric diagnosis became known to others (Campbell & Schraiber, 1989). Additionally, individuals with mental illnesses are often viewed as dangerous or responsible for their disabilities. The view that people are responsible for their condition leads to feelings of anger toward them and causes others to report feeling hesitant to provide them with help (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). People who are viewed to be dangerous are also highly stigmatized, feared, avoided, and recommended to be coercively treated and segregated from the general population (Corrigan et al., 2003).

These stigmatizing beliefs and attitudes can translate into discriminatory behaviors in the primary life domains. For example, in the living domain, stigma and the associated discriminatory behavior of socially distancing oneself from a person limits opportunities for community living. As a result of this type of discrimination, people with a psychiatric diagnosis are often refused the opportunity to rent housing of their choice (Corrigan, Backs, Green, Lickey & Penn, 2001; Levey & Howells, 1995; Madianos, Madianou, Vlachonikolis, & Stefanis, 1987; Penn, Guynan, Daily, Spaulding, Garbin, & Sullivan, 1994). The direct discrimination people with mental illnesses face also influences their opportunities for employment, appropriate rehabilitation services, adequate insurance coverage, and social acceptance (Page, 1995; Wahl, 1999).

The internal effects of stigma are evidenced by the psychological and emotional impact of being stigmatized and have harmful consequences on the quality of life of people with psychiatric disabilities (Graf, Lauber, Nordt, Ruesch, Meyer, & Rossler, 2004). When individuals endorse stigmatizing beliefs, they also report higher levels of avoidance and refusal to help a person with a psychiatric diagnosis (Corrigan et al., 2003). Individuals with mental illnesses experience rejection and social isolation (Brockington, Hall, Levings, & Murphy, 1993; Lauber, Nordt, Falcato, & Rossler, 2002, 2004; Link, Cullen, Mirotznik, & Struening, 1992) as well as increased stress and anguish (Sokratis et al., 2004), and decreased psychosocial functioning (Wahl, 1999). This in turn fosters feelings of anger, hurt, sadness, and discouragement (Wahl, 1999) and can lead to depression, anxiety, and low self-esteem (Farina, 1981; Link, 1987; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). Stigma negatively affects feelings of social connectedness, results in withdrawal from or limited social and occupational functioning, and can work against people's efforts in recovery (Fink & Tasman, 1992; Link, 1987; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Perlick et al., 2001; Satcher, 1999; Wahl, 1999).

Fear of discrimination can result in reduced help-seeking behavior, service utilization, and treatment outcomes for people with mental illnesses (Link & Phelan, 1999; Markowitz, 1998; Sirey, 2001). Research indicates that nearly half of all Americans who have a mental illness do not seek help (Satcher, 1999). For those who do seek treatment, stigma and discrimination affect the acceptance of a diagnosis and impact a person's adherence to treatment (Sokratis et al., 2004). Stigma is also related to individuals' discontinuation of medications and increased social impairment (Sirey, 2001; Perlick et al., 2001).

Anti-Stigma Efforts

Stigmatizing attitudes are changeable, despite stigma's pervasive nature and the negative consequences associated with stigmatizing attitudes, and the resulting discriminatory behaviors (Corrigan et al., 2001; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Link & Cullen, 1986; Penn et al., 1994; Penn, Kommana, Mansfield, & Link, 1999). A growing body of research suggests that personal experience with people who have a mental illness can reduce stigmatizing attitudes (Alexander & Link, 2003). Studies have also found that successful strategies for reducing stigmatizing beliefs should include educating the public about mental illnesses and facilitating contact between the public and people who have mental illnesses (Corrigan &
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Methods

Participants

Four hundred and twenty-six high school students anonymously participated in this study. No individually identifying information was collected from the participants. The data was collected from four different high schools that were located in three New Jersey counties (i.e., Hudson, Somerset, and Ocean). These counties represent the northern, central, and southern regions of the state, respectively. Two hundred and seventy-seven of these students completed an assessment both prior to and after viewing the presentation (109 students were from the central region and 168 students were from the southern region). One hundred and forty-nine students completed the assessment only after watching the presentation (33 students were from the northern region and 116 students were from the southern region).

Measures

The Attribution Questionnaire—Short Form for Children (Watson et al., 2004) was used to collect participant reactions to a short vignette describing a new student who has a mental illness and will be joining the student’s class. This measure was derived from the original Attribution Questionnaire—27 (AQ–27; Corrigan et al., 2003; Corrigan et al., 2002) that assesses nine constructs: responsibility, pity, anger, dangerousness, fear, help, coercion, segregation, and avoidance. The AQ–27 has established high reliability (Corrigan et al., 2003) and a supported factor structure (Corrigan et al., 2002). The Attribution Questionnaire—Short Form for Children was developed to be administered to children and contains eight questions that assess all of the constructs from the original AQ–27, except for the coercion construct. A ninth question is also presented that asks...
the participants if they would be willing to seek mental health treatment if they were in need of it (Watson et al., 2004). The Likert-type scale used in the Attribution Questionnaire—Short Form for Children ranges from 1 (none at all) to 9 (very much). Six of the nine items assess negative attributions related to stigma (e.g., How dangerous would you feel Charlie is?) and three items evaluate positive feelings and behaviors toward the individual with mental illness described in the vignette (e.g., How likely is it that you would help Charlie with school work?).

Content Development

The New Jersey Division of Mental Health Services funded this project, entitled "Reducing Stigma by Meeting and Learning from People with Mental Illness," in 2004. The development of content for the five presentation modules involved the collaboration between three faculty members in the Department of Psychiatric Rehabilitation at UMDNJ, staff members from Collaborative Support Programs of New Jersey (CSP-NJ), and 19 individuals with serious mental illnesses. Each content module was developed by three to four consumers and a faculty advisor. The consumers are all individuals who have received mental health services, have relevant life experience with the content covered in the module, and may have provided services to individuals with serious mental illnesses (i.e., consumer/peer providers). The faculty advisors and consumers met to develop an outline for each content module. Sections of the outline were assigned to group members with the expectation that prior to the next meeting each person would conduct the research necessary to be adequately informed and able to share information about his or her assigned topic. These small groups participated in three to four subsequent meetings in which information from each member was compiled to develop a PowerPoint slide presentation. Information was based on personal experiences as well as a review of research on the topic area. The PowerPoint slide presentations include a description of the topic area and questions to promote discussion among the audience and presenters, as well as personal stories provided by the presenters. After each module was completed, it was sent to a consumer with extensive expertise in that area for editing and feedback.

Five modules have been developed:

- Recovery from Serious Mental Illness is Possible, People with Mental Illness Can Live Independently, People with Mental Illness Can Work, Meeting People with Mental Illness, and Self Help, Treatment, and Rehabilitation are Effective. The aforementioned modules are co-presented by one faculty advisor and two to three consumer presenters. Presentation of a module lasts between 60 and 90 minutes, depending on the extent of the question and answer segment. The Recovery module was most often requested by participating high schools, as it provides the most comprehensive overview. Therefore, only the Recovery module was evaluated in the current study.

Description of the Recovery Module

The Recovery presentation begins with a question that evokes the audience's thoughts about the label "mentally ill." The module includes the definition of mental illness provided by the Surgeon General, the effects of stigma on people with psychiatric illnesses, and common myths and facts. Some famous people who have been either diagnosed or recorded to have episodes of mental illness are discussed, with particular emphasis on those most familiar to audience members. After the statistic of those affected by mental illness is presented, the discussion shifts to definitions of mental health and recovery. Stages of recovery, treatment for psychiatric illness, and overall wellness are discussed in conjunction with the personal stories of the presenters.

Each speaker describes his or her history, challenges, and strategies that have promoted personal recovery. The possible obstacles faced by consumers in the domains of living, learning, working, and social life are presented and one's ability to pursue and achieve goals in all areas is discussed. Throughout the discussion, the barriers and difficulties are described; however, the focus is on the similarities between people with and without mental illness. Each presentation concludes with a discussion of strategies to promote positive and non-discriminatory attitudes toward people with mental illness. Fact sheets are distributed with details about community mental health centers, emergency services, and self-help groups in the geographic area of the audience.

Procedure

In order to solicit interest in the presentations, faculty members attended workshops and conferences around the state to provide information on the program. In addition, information was sent via mass mailings to school principals, guidance counselors, and psychology teachers in New Jersey to advertise the project. The project was also advertised at several faculty meetings at UMDNJ and staff/consumer meetings at CSP-NJ. Once a presentation was scheduled, all project members were outreached by telephone and e-mail to identify their availability. Prior to presenting, each project member rehearsed the slides he or she was interested in presenting. The faculty member provided feedback and suggested strategies to improve presentation style. Speakers were also...
prepared to answer questions that cannot be anticipated, such as specific inquiries related to personal experiences and symptoms. Speakers were encouraged to answer these questions as candidly as possible depending on their comfort level. Five speakers were involved with the presentations discussed in this paper. Three of these five speakers conducted all but one of the presentations.

The Attribution Questionnaire—Short Form for Children (Watson et al., 2004) was administered to participants in two ways: 1) the group of participants received the assessment both prior to and after seeing the presentation or 2) the group of participants received the assessment only after seeing the presentation. The purpose of assessing participants' attributions pre- and post-intervention was to assess changes that occur as a result of the intervention. The authors had concerns, however, about administering the pre- and post-measures so closely together (i.e., 1 hour apart) and the potential for a testing effect. For this reason some participants received the assessments post-intervention only so that the testing effect could be evaluated independent of the intervention effect. It was anticipated that if there was a testing effect present, it would influence the students to report less stigmatizing attitudes.

### Results

The means for each question and the total score (both pre- and post-test) are reported in Table 1. The differences between pre- and post-test scores of the 277 students who received this type of assessment administration were analyzed using Independent Samples t-tests. As indicated in Table 1, there were significant differences between pre- and post-test scores for seven of the nine questions and the total score. Following the presentation, participants reported feeling less pity for Charlie, believing Charlie was less dangerous, not feeling as scared of Charlie, endorsing less that Charlie should be in a special class, being more willing to help Charlie with school work, not trying to stay away from Charlie after school as much, and being more willing to see a counselor or doctor to get help with his depression. The positively worded items (Questions 1, 7, and 9) were reverse scored for the total score computation only so that all items are scored in the same direction. The two questions that did not differ from pre- to post-test were answered by participants in a non-stigmatizing manner before viewing the presentation: therefore, the scores could not decrease enough to show a significant difference. At no time did the participants endorse that Charlie was to blame for his illness or that they would feel angry at Charlie. A floor effect was created by students answering Questions 4 and 6 in a non-stigmatizing way prior to viewing the presentation.

As previously mentioned, the authors had concerns about the potential for a testing effect given that the pre- and post-tests were being administered so closely together. To evaluate the impact of a testing effect, scores of the students who received the post-test

### Table 1—Intervention Effect—Comparing Pre- and Post-test Scores

<table>
<thead>
<tr>
<th>Questions</th>
<th>Pre-or Post-Test</th>
<th>Mean</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I would feel pity for Charlie.</td>
<td>Pre-test</td>
<td>5.63</td>
<td>-10.36***</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>3.73</td>
<td>10.36***</td>
</tr>
<tr>
<td>2. How dangerous would you feel Charlie is?</td>
<td>Pre-test</td>
<td>2.99</td>
<td>-9.20***</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>1.73</td>
<td>9.20***</td>
</tr>
<tr>
<td>3. How scared of Charlie would you feel?</td>
<td>Pre-test</td>
<td>2.74</td>
<td>-6.62***</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>1.75</td>
<td>6.62***</td>
</tr>
<tr>
<td>4. I think Charlie is to blame for the mental illness.</td>
<td>Pre-test</td>
<td>1.42</td>
<td>-5.06</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>1.27</td>
<td>1.45</td>
</tr>
<tr>
<td>5. I think Charlie should be in a special class for kids with problems, not a normal class like mine.</td>
<td>Pre-test</td>
<td>3.97</td>
<td>-4.85***</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>3.03</td>
<td>4.85***</td>
</tr>
<tr>
<td>6. How angry would you feel at Charlie?</td>
<td>Pre-test</td>
<td>1.38</td>
<td>-5.06</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>1.26</td>
<td>1.28</td>
</tr>
<tr>
<td>7. How likely is it that you would help Charlie with school work?</td>
<td>Pre-test</td>
<td>5.51</td>
<td>-3.73***</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>6.24</td>
<td>3.73***</td>
</tr>
<tr>
<td>8. I would try to stay away from Charlie after school.</td>
<td>Pre-test</td>
<td>3.26</td>
<td>-4.33***</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>2.51</td>
<td>4.33***</td>
</tr>
<tr>
<td>9. Would you be willing to see a counselor or doctor to get help with your depression?</td>
<td>Pre-test</td>
<td>5.32</td>
<td>-4.81</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>6.22</td>
<td>4.81***</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td>Pre-test</td>
<td>28.99</td>
<td>-4.86***</td>
</tr>
<tr>
<td></td>
<td>Post-test</td>
<td>25.17</td>
<td>4.86***</td>
</tr>
</tbody>
</table>

*** p ≤ .000
TABLE 2—POST-TEST SCORES—INFLUENCE OF TESTING EFFECT

<table>
<thead>
<tr>
<th>Test Administered</th>
<th>N</th>
<th>Mean</th>
<th>Initial t-test Effect Size—Intervention (d)</th>
<th>Testing Effect (f)</th>
<th>Effect Size—Testing (d)</th>
<th>Effect Size—Difference (d)</th>
<th>Recalculated Intervention Effect (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Post</td>
<td>149</td>
<td>4.87</td>
<td>-10.36***</td>
<td>-.926</td>
<td>-6.36***</td>
<td>-.256</td>
<td>2.88**</td>
</tr>
<tr>
<td>Pre and Post</td>
<td>230</td>
<td>6.27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2 Post</td>
<td>149</td>
<td>2.69</td>
<td></td>
<td>9.20***</td>
<td>6.31***</td>
<td>.157</td>
<td>1.97*</td>
</tr>
<tr>
<td>Pre and Post</td>
<td>231</td>
<td>1.73</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3 Post</td>
<td>149</td>
<td>2.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre and Post</td>
<td>231</td>
<td>1.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p ≤ .05; ** p ≤ .01; *** p ≤ .000

**Conclusions**

The purpose of this study was to examine whether an informational presentation provided by consumers of mental health services could reduce stigmatizing attitudes toward people with mental illnesses among high school students. The results of this study indicate that a 1-hour informational session developed and facilitated by consumers of mental health services can significantly affect the attitudes of adolescents toward people with major mental illnesses. The results confirm that when the three effective approaches to decreasing stigma (i.e., presenting accurate information about mental illness and the real possibility of recovery, including consumers in the development and facilitation of the presentation, and sharing personal stories of recovery) are incorporated into a presentation, stigmatizing attitudes are decreased. As measured by the Attribution Questionnaire—Short Form for Children (Watson et al., 2004), adolescents who viewed the educational presentation demonstrated less stigmatizing attitudes on each of the following constructs: pity, dangerousness, fear, help, segregation, and avoidance.

Based on these results, it can be suggested that high school curricula should include structured programs to improve adolescents’ attitudes toward people with mental illnesses. In an attempt to reduce stigmatizing attitudes and discriminatory behaviors in later life, educational strategies targeted at reducing misconceptions about mental illnesses held by teenagers are critical. Many students are related to someone with a mental illness or are experiencing significant mental health issues themselves. In addition to the efforts to reduce stigma, educational interventions can also alleviate some of the shame and misunderstanding regarding seeking mental health treatment. These types of programs can serve as public education for teens who may be suffering from an undiagnosed condition, may perhaps develop a mental illness in the future, or need information to better deal with a friend or loved one affected by major mental illnesses.

Although this study is among the very few published reports of anti-stigma efforts aimed at reducing negative attitudes toward people with mental illness among the adolescent population, a couple of points of interest and some legitimate limitations need to be addressed. First, as stated previously, the administration of the
questionnaires both pre- and post-presentation (i.e., only 60–90 minutes apart) presents the potential for a testing effect. The authors addressed this concern by also administering the questionnaires as post-tests only to allow for comparison of the results. As described, it seems that the effect of the presentation was significant above and beyond the effect of the questionnaire administration. However, despite the efforts of the authors to address this limitation statistically, the testing administration remains a limitation of the study.

Secondly, the lack of demographic data about the sample and the inability to test for the impact of gender serves as a limitation. Future studies may want to examine the role of gender on the attitude change measured. The data collected for this study also does not allow for analysis of a potential presenter effect. Because the same speakers were used for all but one of the presentations it is impossible to assess the effect of presenter. It will be important in future data collection to evaluate this.

It was hypothesized that after viewing the 1-hour presentation, a decrease in stigmatizing attitudes would be found. This hypothesis was confirmed; however, the very brief follow-up period merely suggests that a change can be induced and provides no indication that it can be sustained. The current study cannot suggest that this measured change in attitude is sustained over time. Lastly, another possible criticism of the current study is the lack of information gained regarding discriminatory behaviors. This study evaluated attitudes toward people with mental illness but did not assess the presence of any associated discriminatory behaviors. Similar to other studies evaluating stigma, this study can only speak to self-reported attitudes in response to a theoretical person and suggestions of behavior in imagined situations. Therefore, the results can not predict future interpersonal behavior toward people with mental illness. Questions that remain are: Does the change in attitude actually affect behavior? Does attitude change lead to more tolerance and acceptance of mental illness? Does attitude change lead to less bullying and exclusion of people with mental illness by these students?

Future research aimed at assessing attitudes toward people with mental illnesses among the adolescent population should focus on the sustainability of decreased stigmatizing attitudes; evaluation methods need to determine whether the immediate effect of educational programs to reduce stigmatizing attitudes persists over time. Additionally, it may be helpful to compare the groups on factors such as socioeconomic status of the family, education levels of the parents, gender of the respondents and future career options of the students. These variables may better inform which types of students would most benefit from educational programs. Like other projects that have measured stigmatizing attitudes and beliefs about mental illness, future projects should also assess the effect of psychiatric diagnosis on subsequent attitudinal reports provided by the adolescent population.

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